

Short Form for Reviewing Patient Falls Hospital_____

Note: All falls resulting in a Level 1 injury (death or serious disability lasting seven days or present on discharge) must be reported in accordance with the requirements of 10.07.06. This form may be used in lieu of a root cause analysis.

Please	report	the	fol	lowing:

- 1. Patient date of birth:
- 2. Patient sex:
- 3. Patient admit date:
- 4. Patient admitting diagnoses:
- 5. Event day, date, time:
- 6. Was event witnessed?
- 7. Was family notified? Was physician notified?
- 8. Number of routine medications:
- 9. Functional and cognitive contributory or causal factors:

a.	Pt. assessed as fall risk	Υ	N	Root	Contr.
				cause	factor
b.	Appropriate interventions in place				
c.	Recent change in meds				
d.	Incontinent or foley				
e.	Dependant for ADLs				
f.	Gait or balance limitations				
g.	Need for assistive devices				
h.	Confusion or memory deficits				
i.	Sedated or on pain meds				
j.	Related medical conditions				
k.	Did care plan address these issues?				

10. Did communication breakdown contribute to fall?

a.	Staff to staff	Υ	Ν	RC	CF
b.	Staff to/from patient				
С.	Staff to/from family/other				
d.	Physician to/from patient/staff				
e.	Patient/family education				

11. Environmental factors:

a.	Restraints in use	Υ	N	RC	CF
b.	Protective devices in use				
C.	Adequate footwear				
d.	Bed side rails, Number				
e.	Floor dry?				

f.	Physical obstacles
g.	Adequate personnel
h.	Adequate lighting
i.	Bed/wheelchair locked
j.	Equipment failure
k.	Bed alarm in use
١.	Fall during transfer
m.	Other

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13. Patient-specific care plan changes:

14. Facility post-fall actions